# The Cass affair

## *A report to NHS England distorted its scientific sources and concealed use of hate group material, argues* David Bahry[1]

### Introduction

A year ago, the UK indefinitely banned the use of puberty blockers by transgender adolescents.[i] This contradicted the standards of care of the World Professional Association for Transgender Health.[ii] Instead it followed the recommendations of Hilary Cass, chair of the *Cass Review*.[iii,iv]

Irregularities surround the process of the Cass Review (Figure 1). The Review is presented as motivating the ban—yet Cass' initial recommendation that NHS England restrict puberty blockers was made in July 2022, almost two years before the Review was completed. Cass introduces unsourced speculative hypotheses—such as that gender dysphoria is being spread by "social contagion" or "pornography"—that were not mentioned in her stated evidence base of NICE[v,vi] and University of York reviews[vii], but are familiar from anti-trans political activists.[viii] Troublingly, one such activist group—the US-based "Society for Evidence-based Gender Medicine" (SEGM), which presents itself to scientists as a scientific society[ix]—has been implicated in the Review and the NHS policy working group that gave rise to it (Supplemental Material).

Internationally, the Cass Review has been weaponized by the anti-LGBT hate movement.[x] It has been cited before the Supreme Court of the United States, in support of bans of puberty blockers (*US v. Skrmetti*) and against bans on conversion therapy (*Chiles v. Salazar*), by Christian nationalist groups such as "Alliance Defending Freedom" (ADF) and "American College of Pediatricians" (ACPeds). In the former, accompanying the Christian nationalists was SEGM.

To understand how this happened, it will be necessary to examine the evidence—both the medical evidence itself and the documentary record.

In this analysis I show that the Cass Review repeatedly distorted its scientific sources; give evidence that the ban had been predetermined by the time of the commissioning of the Review in September 2020; and confirm that the Review obscured its use of material from SEGM. I infer that the ban was not driven by evidence, but rather by a "social contagion" speculation emerging in 2015 and transmitted to Cass by SEGM affiliates during January–September 2020.

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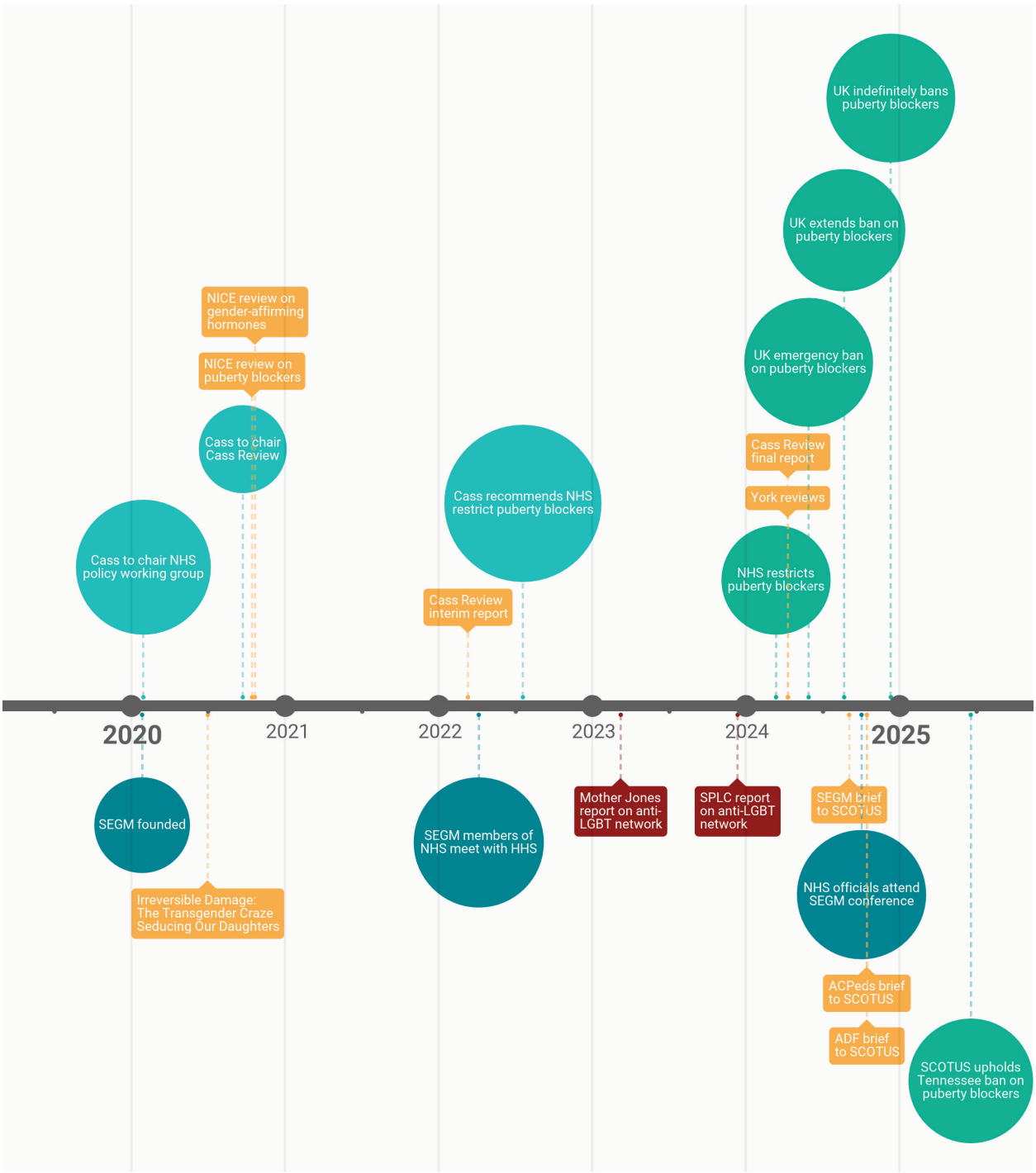
UK indefinitely bans puberty blockers
UK extends ban on puberty blockers
NICE review on gender-affirming hormones
NICE review on puberty blockers
UK emergency ban on puberty blockers
Cass to chair Cass Review
Cass Review final report
Cass recommends NHS restrict puberty blockers
York reviews
Cass to chair NHS policy working group
NHS restricts puberty blockers
Cass Review interim report
2020
2021
2022
2023
2024
2025
SEGM founded
Irreversible Damage: The Transgender Craze Seducing Our Daughters
SEGM members of NHS meet with HHS
Mother Jones report on anti-LGBT network
SPLC report on anti-LGBT network
SEGM brief to SCOTUS
NHS officials attend SEGM conference
ACPeds brief to SCOTUS
ADF brief to SCOTUS
SCOTUS upholds Tennessee ban on puberty blockers

*Figure 1. Events surrounding the Cass Review and the restriction of puberty blockers for trans adolescents. In January 2020, NHS England commissioned a review of puberty blockers and gender-affirming hormones under its standardised protocol, to be chaired by Cass and informed by the NICE reviews. In September 2020 this was replaced with the Cass Review, which commissioned the University of York reviews. In July 2022 Cass recommended that NHS withhold puberty blockers from trans adolescents (unless they consent to an NHS clinical trial). ADF, ACPeds, and SEGM are designated as anti-LGBT hate groups by SPLC [https://www.splcenter.org/resources/extremist-files/anti-lgbtq/]. Documentation in Supplemental Material. ACPeds, American College of Pediatricians; ADF, Alliance Defending Freedom; HHS, USA Department of Health and Human Services; NHS, National Health Service; NICE, National Institute for Health and Care Excellence; SCOTUS, Supreme Court of the United States; SEGM, Society for Evidence-Based Gender Medicine; SPLC, Southern Poverty Law Center.*



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**Background**

The medical consensus approach to treating gender dysphoria, when carefully diagnosed, is gender-affirming care, which in adults or older adolescents may include gender-affirming hormones and/or surgeries.[ii] In trans adolescents, there is often also an initial period of reversible puberty blockers—to prevent the exacerbation of gender dysphoria by unwanted secondary sex characteristics, such as vocal changes and facial hair, or breasts and menses—until they are ready and permitted to proceed further (or else change their mind). Of course, beginning with puberty blockers, rather than immediately prescribing gender-affirming hormones, is a precaution; the adolescent *can* change their mind, but there is no expectation that most *will*, given that most adolescents seeking and receiving puberty blockers really are trans.

Adult gender-affirming care has a century-long history, pioneered by Magnus Hirschfeld in prewar Berlin, whose *Institut für Sexualwissenschaft* was destroyed and its books burned by the Nazis in 1933.[xi] Adolescent gender-affirming care is younger, having a forty-year history. It was pioneered in the Netherlands by Louis Gooren, Henriette Delemarre-van de Waal, Peggy Cohen-Kettenis, and Annelou de Vries, and their approach is known as the *Dutch approach*.[xii]

The delay was in part due to worries about desistance. (Early studies had found that most effeminate pre-pubescent boys grow up to be gay men, not trans women.) However, by the 80s it had become clear that adolescents with lasting gender dysphoria do tend to persist as trans. It was also obvious that requiring trans adolescents to undergo unwanted endogenous puberty itself carried harms, both immediate and lasting. This was the context in which Gooren and Cohen-Kettenis, at their clinic in Utrecht, in 1991 lowered the age limit from 18 to 16.

Meanwhile in 1986, the 12-year-old trans boy F.G. was dreading female puberty. In Amsterdam, Delemarre-van de Waal, an endocrinologist with expertise in precocious puberty, realized the solution was obvious: she prescribed F.G. puberty blockers and, when he turned 16, referred him to Cohen-Kettenis. Years later, interviewed in a 2021 book, F.G. called it "truly lifesaving."[xii]

The Dutch group first published their approach as a theoretical paper in 1996[xiii], followed by the F.G. case study in 1998[xiv] and a cohort study in 2011 (after puberty blockers)[xv] and 2014 (after proceeding to medical transition).[xvi] After the clinical success of F.G., the use of puberty blockers spread to other clinics, with some also initiating their own cohort studies, including the UK *Early Intervention Study* led by Polly Carmichael, published in 2021[xvii], and the US *Trans Youth Care Study* led by Johanna Olson-Kennedy with publications ongoing.[xviii]



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Unsurprisingly, now that clinics had a way to help trans adolescents, trans adolescents also began going to the clinic more—especially trans boys, who now had a way to avoid breasts or menses. (Although neither fact is surprising, some have speculated that these quantitative shifts instead represented a qualitatively new phenomenon. It follows that prior data on the rarity of desistance can be dismissed as irrelevant, and its continued rarity can be framed as surprising.)

Before discussing the cohort studies' results, some elements of scientific literacy must be reviewed. First: a randomized controlled trial is not always feasible, and that's ok. We do not test parachutes by throwing people out of planes without one; we already know what happens, and what happens is unethical. Second: when the default outcome would be a harmful change, "no change" means success. A parachute keeps you alive when you hit the ground.

With these in mind, let us review de Vries et al. (2011) and Carmichael et al. (2021), on which Cass focuses. Neither included a negative control, for reasons similar to the parachute: we know what harms result from withholding treatment. Both found the same central positive result: when the trans adolescents received puberty blockers, their dysphoria did not get worse over time, as it would otherwise, but instead remained stable. In short: puberty blockers *worked*.

**The Cass Review distorted its scientific sources**

Here I show that the Cass Review repeatedly distorted its own scientific sources (Table 1).

The most obvious instance concerns the success criteria for puberty blockers. Puberty blockers prevent the exacerbation of dysphoria; they have never been expected to reverse it. Yet Cass transforms this success into failure, writing: "*However*, no changes in gender dysphoria or body satisfaction were demonstrated."[iv] This is as misguided as claiming that a parachute did not work because the skydiver only remained alive. This was despite clear warnings in both de Vries et al. and Carmichael et al. It was also despite a clear warning in the NICE review, which said: "It is plausible … that a lack of difference in scores from baseline to follow-up *is the effect* of GnRH analogues" (emphasis added).[v]

Cass also distorts the effect of gender-affirming hormones on suicidality. In one instance, this was inherited from the York review, which included four studies addressing suicidality. All four observed lower suicidality associated with gender-affirming hormones; in three, this was statistically significant. Yet Cass, following the York review, describes this as "inconsistencies."[iv]

In the most sophisticated instance, Cass even implies that gender-affirming hormones may *cause* suicidality. She first cites a paper from the *Trans Youth Care* project as reporting suicidal



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***Table 1. The Cass Review distorted its scientific sources***

| The Cass Review[1,2] | Source material | Bahry comment |
|---|---|---|
| **14.26** Only two moderate quality studies looked at gender dysphoria and body satisfaction … Neither reported any change before or after receiving puberty suppression.[1]<br><br>**14.49** The University of York systematic review found no evidence that puberty blockers improve body image or dysphoria …[1]<br><br>**82.** However, no changes in gender dysphoria or body satisfaction were demonstrated.[1] | As expected, puberty suppression did not result in an amelioration of gender dysphoria. Previous studies have shown that only [gender reassignment] consisting of [cross-sex hormone] treatment and surgery may end the actual gender dysphoria.[3]<br><br>This… was anticipated, given that GnRHa does not change the body in the desired direction, but only temporarily prevents further masculinization or feminization.[4] | The two relevant studies included in the University of York systematic review were de Vries et al.[3] and Carmichael et al.[4] Both were clear that the aim and expected success of puberty blockers is to prevent the exacerbation of dysphoria, not to reverse it.<br><br>NICE was also clear that the aim and expected success of puberty blockers is to prevent the exacerbation of dysphoria, not to reverse it.[5]<br><br>Paragraph 3.29 of the interim report shows that the Cass Review was aware of such expectations.[2] |
| **15.22** There were inconsistencies regarding suicidality and/or self-harm, with three of four studies reporting an improvement and one no change.[1]<br><br>**15.36** … Some clinicians feel under pressure to support a medical pathway based on widespread reporting that gender-affirming treatment reduces suicide risk. This conclusion was not supported by the above systematic review.[1] | … a significant increase in levels of general well-being and a significant decrease in levels of suicidality were observed.[6]<br><br>… treatment needs due to depression, anxiety and suicidality/self-harm had diminished.[7]<br><br>Findings support a relationship between access to GAHT and lower rates of depression and suicidality among transgender and nonbinary youth.[8]<br><br>Severity of anxiety and depression was significantly lower in the T treated group relative to the UT group, along with a trend of lower suicidality.[9] | All four studies included in the York review observed lower suicidality associated with gender-affirming hormones. In three, the association was statistically significant[6-8]; in one, it was just a trend.[9]<br><br>When a trend is too small, given the study's statistical power, to be statistically significant, that study is not enough to reject the null hypothesis. This does not mean it has confirmed the null hypothesis.<br><br>Four studies, all observing at least a trend of reduced suicidality, do not constitute "inconsistencies" sufficient to undermine reporting that gender-affirming hormones reduce suicide risk. |
| **15.40** The authors of a paper reporting on psychosocial outcomes of 315 young people treated with masculinising/feminising hormones … stated that the most common adverse event was suicidal ideation (11 participants [3.5%]) and two participants [0.6%] died by suicide. Suicidality at baseline was one of the exclusion criteria for this study.[1] | **4.6 Gender-Affirming Hormone Cohort Youth Exclusion Criteria**<br>…<br>4.6.4 Visibly distraught (e.g., suicidal, homicidal, exhibiting violent behavior) at the time of consent or the baseline survey …[10] | The paper is from the *Trans Youth Care* study.[10] The exclusion criterion, as described in the paper's supplemental material and in a previous publication from that study[11], was visibly suicidal behaviour during the baseline survey—not a history of suicidal ideation or suicide attempts, both previously found to be common at baseline in this cohort.[12] |
| **80.** The original rationale for use of puberty blockers was that this would buy 'time to think' …[1]<br><br>**83.** Moreover, given that the vast majority of young people started on puberty blockers proceed from puberty blockers to masculinising/feminising hormones, there is no evidence that puberty blockers buy time to think, and some concern that they may change the trajectory of psychosexual and gender identity development.[1]<br><br>**3.31.** The most difficult question is whether puberty blockers do indeed provide valuable time for children and young people to consider their options, or whether they effectively 'lock in' children and young people to a treatment pathway which culminates in progression to feminising/masculinising hormones. Data from both the Netherlands and the study conducted by GIDS demonstrated that almost all children and young people who are put on puberty blockers go on to sex hormone treatment.[2] | However, the delay of such treatment until after the development of secondary sex characteristics has obvious drawbacks for transsexual individuals.[13]<br><br>The most important advantage of pubertal delay *over cross-sex hormone treatment* is that no irreversible steps are taken. The therapist and transsexual can explore problems which *possibly* underlie the cross gender identity or clarify gender confusion under less time pressure [emphasis added].[13]<br><br>The great majority of this cohort went on to start cross-sex hormones, as was hypothesized given the severity and continuation of their GD.[3] | Gooren and Delemarre-van de Waal's original aim was "to spare them the torments of developing the secondary sex characteristics of a sex they view as not their own."[14] Cohen-Kettenis described this as "obvious".[13] NICE was clear that the aim of puberty blockers is to "alleviate the distress associated with the development of secondary sex characteristics".[4]<br><br>This can be achieved by prescribing gender-affirming hormones immediately, or by first prescribing puberty blockers. "Time to think" is a precaution. Like any precaution, it is not hoped to be needed.<br><br>Both Dutch and UK studies were stringent in prescription. Furthermore, there is no evidence that many cis adolescents are seeking puberty blockers.<br><br>The unsurprising rarity of desistance, given the intentional rarity of over-prescribing puberty blockers, is not evidence that puberty blockers do not work, nor that puberty blockers cause persistence. |


1. Cass (2024). Cass Review, final report.
2. Cass (2022). Cass Review, interim report.
3. de Vries et al. (2011). 10.1111/j.1743-6109.2010.01943.x
4. Carmichael et al. (2021). 10.1371/journal.pone.0243894
5. NICE (2020). Evidence review on puberty blockers.
6. Allen et al. (2019). 10.1037/cpp0000288
7. Kaltiala et al. (2022). 10.1080/08039488.2019.1691260
8. Green et al. (2022). 10.1016/j.jadohealth.2021.10.036
9. Grannis et al. (2021). 10.1016/j.psyneuen.2021.105358
10. Chen et al. (2023). 10.1056/nejmoa2206297
11. Olson-Kennedy et al. (2019). 10.2196/14434
12. Chen et al. (2021). 10.1016/j.jadohealth.2020.07.033
13. Cohen-Kettenis & van Goozen (1998). 10.1007/s00787005007
14. Gooren & Delemarre-van de Waal (1996). 10.1300/J056v08n04_05




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ideation and two deaths by suicide, then juxtaposes this to a claim that "Suicidality at baseline was one of the exclusion criteria of the study."[iv] In fact, that cohort had a history of suicidality; the criterion was to not be visibly attempting or threatening suicide during the baseline survey.

The most insidious concerns the aim of puberty blockers. As NICE explained, the aim is "to alleviate the distress associated with the development of secondary sex characteristics"[v] in a reversible way that still leaves time to think. Cass inverts this logic, claiming that "The original rationale for use of puberty blockers was that this would buy 'time to think'"—such that low desistance rates mean there is "no evidence that puberty blockers buy time to think," and cautious prescription of puberty blockers becomes evidence that puberty blockers don't work.[iv]

**The Cass Review's outcome was predetermined**

Here I give two lines of evidence that the Cass Review's outcome was predetermined (Box 1a). In both cases a rationale for why the policy working group and NICE reviews were not enough, and a new remit was needed, was then recycled into a rationale for a ban under the new remit.

The first is Cass' use of evidence quality. The field has long been aware of its shortage of "high certainty" evidence (recall the cohort studies' lack of negative controls). The issue is that during the standardised NHS protocol, this was deemed a reason why NHS England could not yet form a policy decision, such that a new, independent review was needed—yet under that new review it became a new discovery, and the basis for a policy of banning puberty blockers.

The second is the use of demographic shifts. Recall that as clinics became useful to trans adolescents, more began to go; and recall that some speculate that this reflected instead a qualitatively new phenomenon. The Review was among these speculators, even claiming that "*any* data that are available do not relate to the current predominant cohort" (emphasis added).[iii]

Cass explains that this demographic shift was a driving reason why the NICE evidence was not enough, NHS could not form a policy decision, and a new independent review was needed. Yet under that new review, in July 2022, this too became the rationale for a policy of restriction.

**The Cass Review concealed its use of SEGM material**

In the final report, Cass depicts the increase in trans adolescents presenting to NHS with three figures. Her figures 2 and 10 cite a paper from an NHS lead author; figure 11 has no attribution. It has previously been pointed out that this figure is identical to one on the web page of SEGM.

By examining the PDF in Adobe Acrobat, I have confirmed that the embedded image file still contains the SEGM logo (Box 1b). The logo has been covered with a small white rectangle.



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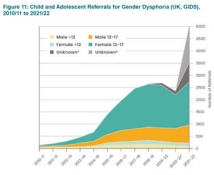
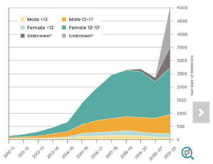
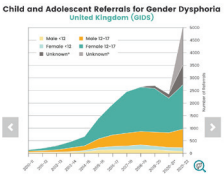
*Box 1. Anatomy of a subversion*

**a) The Cass Review's outcome was predetermined**

| NICE review | Rationale for the Cass Review | Rationale under the Cass Review | Bahry comment |
|---|---|---|---|
| The important outcomes for decision making are impact on body image, psychosocial impact, engagement with health care services, impact on extent of and satisfaction with surgery and stopping treatment. The quality of evidence for all these outcomes was assessed as very low certainty using modified GRADE.[1]<br><br>Evidence was available for bone density, cognitive development or functioning, and other safety outcomes. The quality of evidence for all these outcomes was assessed as very low certainty using modified GRADE.[1] | **3.16** NHS England uses a standardised protocol for developing clinical policies. … agreement was reached on what should be included in the PICO [Population Intervention, Comparator, Outcomes] and subsequently the National Institute for Health and Care Excellence (NICE) was commissioned to review the published evidence, again following a standardised protocol which has strict criteria about the quality of studies that can be included.[2]<br><br>**3.17** Unfortunately, the available evidence was not strong enough to form the basis of a policy position.[2] | We have concluded that there is not enough evidence to support the safety or clinical effectiveness of [puberty suppressing hormones] to make the treatment routinely available at this time.[3]<br><br>Puberty blockers are powerful drugs with unproven benefits and significant risks …[4]<br><br>Dr Cass' review also raised safety concerns around the lack of evidence for these medical treatments.[5] | The shortage of controlled trials, and the low certainty evidence under evidence-scoring systems such as GRADE, was already known.<br><br>The low certainty was highlighted by the NICE reviews, and was cited as a rationale for why NHS England could *not* form a policy position.<br><br>After this was cited as a reason to replace the standardised NHS protocol with the non-standardised Cass Review, it was then re-framed as a new discovery and cited as a reason *for* the policy of restriction. |
| n/a | **3.16** The need for an independent review was clear and driven by the changing situation over the last 10-15 years:<br>…<br>• The marked change in the case-mix, from predominantly pre-pubertal birth-registered males to predominantly post-pubertal birth-registered females, with no clear explanation for this changed demographic.[6] | The rationale for use of puberty blockers at Tanner Stage 2 of development was based on data that demonstrated that children, particularly birth-registered boys who had early gender incongruence, were unlikely to desist once they reached early puberty; this rationale does not necessarily apply to later-presenting young people, including the predominant referral group of birth-registered girls.[7]<br><br>**84.** The Review's letter to NHS England [July 2022] advised that because puberty blockers only have clearly defined benefits in quite narrow circumstances, and because of the potential risks … they should only be offered under a research protocol.[6] | As clinics developed a way to help trans adolescents, who in turn began going to clinics more, referral demographics shifted. Cass speculates that this was instead a qualitatively new phenomenon, such that "*any* data that are available do not relate to the current predominant cohort" (emphasis added).[2]<br><br>The NICE review explicitly excluded a paper on demographic trends in puberty blockers[6], listing the reason "Outcomes – not in the PICO."[1]<br><br>After demographic shifts were excluded under the standard NHS protocol, they were cited as a reason to replace the standard protocol with the Cass Review, and then again under the Cass Review as a reason to restrict puberty blockers. |

**b) The Cass Review concealed its use of SEGM material**

| Cass Review | Cass Review, embedded image | SEGM homepage[9] | Bahry comment |
|---|---|---|---|
|  |  |  | Cass Review uses a figure from the SEGM homepage, without citation and while covering the SEGM logo.<br><br>SEGM is a central node of a network that promotes "rapid onset gender dysphoria," a speculation that trans boys are girls with a social contagion.[10] SEGM's homepage frames the quantitative shifts as a qualitatively novel phenomenon. |

1. NICE (14 Oct 2020). Evidence review on puberty blockers.
2. Cass (10 Mar 2022). Cass Review, interim report.
3. NHS (12 Mar 2024). Clinical policy: puberty suppressing hormones (PSH) for children and young people who have gender incongruence/gender dysphoria.
4. Department of Health and Social Care (11 Dec 2024), quoting Hilary Cass.
5. Department of Health and Social Care (11 Dec 2024), quoting Wes Streeting.
6. Cass (10 Apr 2024). Cass Review, final report.
7. Cass (19 Jul 2022). Letter to NHS [appendix 6 of Cass Review, final report].
8. Lopez et al. (2018). 10.1515/jpem-2018-0048
9. SEGM. https://segm.org/ Accessed 5 Mar 2026. Fair dealing: criticism.
10. SPLC (12 Dec 2023). Timeline. https://www.splcenter.org/resources/reports/timeline-building-pseudoscience-network/



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## Discussion and conclusion

In March 2023, *Mother Jones* reported on a tranche of leaked emails revealing a large, sophisticated network pushing anti-trans litigation and legislation.[xix] The network included, among others, politicians; lawyers; members of ADF, famous for defending discrimination against gay marriage; members of ACPeds, founded to oppose adoption by gay couples; and SEGM founder William Malone. (Malone actively coordinated with the Christian nationalists, e.g. with the ACPeds president showing advance knowledge in 2019 that he was forming a group; Supplemental Material). Later that year, SPLC published a report on the same network, with information such as funding streams and citation network analysis; SEGM was a key node.[xx]

Among the weapons of this network is the "rapid onset gender dysphoria" hypothesis. As one book subtitle describes it, this speculates about a *Transgender Craze Seducing Our Daughters*. Despite the lack of evidence, since the ROGD speculation emerged in 2015 on anti-transgender blogs such as "Transgender Trend," it has been promoted by groups such as ADF and SEGM.[xx]

We have now seen that the Cass Review repeatedly distorted its own sources, and that the rationales used to replace the standard NHS protocol with the Cass Review were then recycled as rationales for restricting puberty blockers. These strange findings become legible in light of a third: Cass was using SEGM as a source. Furthermore, it was already known that SEGM was implicated both in the NHS working group and in the Cass Review (Supplemental Material).

We can now infer a plausible narrative. In January–September 2020, SEGM affiliates in the policy working group introduced Cass to ROGD theory, re-framing the quantitative shifts as a qualitative break. Cass credited the framing (and to some degree even the theory), but under the standard NHS protocol could not use it to justify policy. In September 2020 the Cass Review replaced the NHS protocol, and in July 2022 the framing was finally used to justify policy.

That's not safeguarding.

## Acknowledgements

I thank *Trans Safety Network* for clarifying the source of its information on membership of the NHS policy working group. I thank Dr. Hilary Cass for confirming that the July 19, 2022 letter to NHS was the one in which she made her recommendation to restrict puberty blockers. **AI use statement:** I discussed this paper extensively with *Anthropic*'s Claude over iterative drafts, including for feedback on strengths, weaknesses, proofreading, fact checking, and flow. While fact checking the lack of demographics in the NICE review, Claude noted the excluded paper.



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[i] Department of Health and Social Care. Ban on puberty blockers to be made indefinite on experts' advice. 2024 Dec 11. Available from: https://www.gov.uk/government/news/ban-on-puberty-blockers-to-be-made-indefinite-on-experts-advice [The indefinite ban also followed a public consultation which unaccountably included anti-trans activist groups such as "Genspect," "Transgender Trend," "Bayswater Support Group," and "LGB Alliance."]

[ii] Coleman E, Radix AE, Bouman WP, Brown GR, de Vries ALC, Deutsch MB, et al. Standards of care for the health of transgender and gender diverse people, version 8. Int J Transgender Health. 2022;23(Suppl 1):S1-S259. doi:10.1080/26895269.2022.2100644

[iii] Cass H. Independent review of gender identity services for children and young people: interim report. 2022. Available from: https://webarchive.nationalarchives.gov.uk/ukgwa/20250310143846/https://cass.independent-review.uk/home/publications/interim-report/

[iv] Cass H. Independent review of gender identity services for children and young people: final report. 2024. Available from: https://webarchive.nationalarchives.gov.uk/ukgwa/20250310143933/https://cass.independent-review.uk/home/publications/final-report/

[v] National Institute for Health and Care Excellence. Evidence review: Gonadotrophin releasing hormone analogues for children and adolescents with gender dysphoria. 2020. Available from: https://webarchive.nationalarchives.gov.uk/ukgwa/20250310144323/https://cass.independent-review.uk/nice-evidence-reviews/

[vi] National Institute for Health and Care Excellence. Evidence review: gender-affirming hormones for children and adolescents with gender dysphoria. 2020. Available from: https://webarchive.nationalarchives.gov.uk/ukgwa/20250310144323/https://cass.independent-review.uk/nice-evidence-reviews/

[vii] University of York systematic reviews. Arch Dis Child. 2024;109 (Issue Suppl 2). Available from: https://adc.bmj.com/content/109/Suppl_2

[viii] Shrier A. Irreversible Damage: The Transgender Craze Seducing Our Daughters. Regnery Publishing. 2020.

[ix] Guyatt G, Brignardello-Petersen R, Ibrahim S, Roldán-Benitez Y, Couban R. Systematic reviews related to gender-affirming care. 2025 Aug 14. Available from: https://hei.healthsci.mcmaster.ca/systematic-reviews-related-to-gender-affirming-care/

[x] Southern Poverty Law Center. Anti-LGBTQ [Internet]. [cited 2026 Mar 3]. Available from: https://www.splcenter.org/resources/extremist-files/anti-lgbtq/

[xi] Wolf-Gould C, Denny D, Green J, Lynch K, eds. A History of Transgender Medicine in the United States: From Margins to Mainstream. SUNY Press; 2025.

[xii] Bakker A. The Dutch Approach: Fifty Years of Transgender Health Care at the VU Amsterdam Gender Clinic. Boom Uitgevers; 2021.

[xiii] Gooren L, Delemarre-van de Waal H. The feasibility of endocrine interventions in juvenile transsexuals. J Psychol Human Sex. 1996;8(4):69-74. doi:10.1300/J056v08n04_05

[xiv] Cohen-Kettenis P T, van Goozen SH. Pubertal delay as an aid in diagnosis and treatment of a transsexual adolescent. Eur Child Adolesc Psychiatry. 1998;7(4):246-248. doi:10.1007/s007870050073

[xv] de Vries ALC, Steensma TD, Doreleijers TAH, Cohen-Kettenis PT. Puberty suppression in adolescents with gender identity disorder: a prospective follow-up study. J Sex Med. 2011;8(8):2276-2283. doi:10.1111/j.1743-6109.2010.01943.x

[xvi] de Vries ALC, McGuire JK, Steensma TD, Wagenaar ECF, Doreleijers TAH, Cohen-Kettenis PT. Young adult psychological outcome after puberty suppression and gender reassignment. Pediatrics. 2014;134(4):696-704. doi:10.1542/peds.2013-2958

[xvii] Carmichael P, Butler G, Masic U, Cole TJ, De Stavola BL, Davidson S, et al. Short-term outcomes of pubertal suppression in a selected cohort of 12 to 15 year old young people with persistent gender dysphoria in the UK. PLoS One. 2021;16(2):e0243894. doi:10.1371/journal.pone.0243894

[xviii] Olson-Kennedy J, Chan Y-M, Garofalo R, Rosenthal SM. The Impact of Early Medical Treatment in Transgender Youth. NIH Grant R01 HD082554. Eunice Kennedy Shriver National Institute of Child Health and Human Development. 2015. Available from: https://reporter.nih.gov/project-details/8965408

[xix] Pauly M. Inside the secret working group that helped push anti-trans laws across the country. Mother Jones. 2023 Mar 8. Available from: https://www.motherjones.com/politics/2023/03/anti-trans-transgender-health-care-ban-legislation-bill-minors-children-lgbtq/

[xx] Southern Poverty Law Center. Combating Anti-LGBTQ+ Pseudoscience Through Accessible Information Narratives. 2023 Dec 12. Available from: https://www.splcenter.org/resources/reports/captain/



doi:10.5281/zenodo.18944611